

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04471

Reg. Dist. No.

4481

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 369 W. Main St.				d. STREET ADDRESS 369 W. Main St.			
3. NAME OF DECEASED (Type or print) First Michael Middle Bowman Last Bowman				4. DATE OF DEATH Month 4 Day 20 Year 19 58			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2 1873	
				9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 4 Days 20 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY Germany		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME no information				14. MOTHER'S MAIDEN NAME No information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-07-1607		17. INFORMANT From Papers in his possession.			
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-22-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/1958		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home				24a. REC'D BY REGISTRAR APR 28 58		24b. REGISTRAR'S SIGNATURE W. Redick	
ADDRESS Elkton, Md.				DATE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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BUREAU V. S.

APR 28 1912

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04472

Reg. Dist. No. 96

4492

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 1mo.25 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEO Middle (NMI) Last CASON		4. DATE OF DEATH Month April Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-06
9. AGE (In years last birthday) 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Anderson, S. C.	
13. FATHER'S NAME James Cason		14. MOTHER'S MAIDEN NAME Rosa White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 225-10-4794	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, uremic poisoning (clinical) 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis bilateral, organism unknown DUE TO (c) Urethral obstruction due to scarring PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized, moderately severe INTERVAL BETWEEN ONSET AND DEATH 5 days unknown unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) unknown	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February 11, 19 58 , to April 5, 19 58 , and that death occurred at 11:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) D.C. DATE SIGNED 4-7-58 ACTUAL SIGNATURE S. P. LACERVA M.D. V. A. Hospital, Perry Point, Md. PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/7/58	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR APR 11 '58	24b. REGISTRAR'S SIGNATURE W. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. A.

APR 11 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4493 CERTIFICATE OF DEATH

04473

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT				c. LENGTH OF STAY IN 1b 1yr. 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 215 N. Washington			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JERRY W. CLEVELAND				4. DATE OF DEATH Month Day Year April 20 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1891	
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months Days Hours Min. 66		IF UNDER 24 HRS. Months Days Hours Min. 66			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME B. F. CLEVELAND				14. MOTHER'S MAIDEN NAME MARY A COBB			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I				16. SOCIAL SECURITY NO. 251-34-5305		17. INFORMANT Address Hospital Records, VAH., Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial fibrosis, severe, left ventricle DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized, severe PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unknown unknown unknown							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1957 , to April 20, 1958 , and that death occurred at 12:55AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 4-21-58 ACTUAL SIGNATURE S. P. LACERVA M.D. PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL				22b. DATE THEREOF 4/21/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia.							
23. FUNERAL DIRECTOR'S SIGNATURE PEARLINGTON & SON				ADDRESS Hayre DeGrace, Md.		24a. REC'D BY REGISTRAR DATE APR 23 '58	
24b. REGISTRAR'S SIGNATURE Overland							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 3

APR 23 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04474

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fredricktown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Fredericktown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Richardson</u> Middle <u>Cole</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-16-1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat Yd. Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boat harbor</u>	
11. BIRTHPLACE (State or foreign country) <u>Dover, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mark Worcester Cole</u>		14. MOTHER'S MAIDEN NAME <u>Ida Donovan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>577-09-5199</u>	
17. INFORMANT <u>Mrs. Harry R. Cole. Georgetown. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> DUE TO (c) <u>420.1</u> DUE TO causes lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R.C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GEORGETOWN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>GEORGETOWN Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows, Millington, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 16 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Ed. Fellows</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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BUREAU V. S.

APR 16 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #9-Film G228 4/25/58-mb

04475

CERTIFICATE OF DEATH

Reg. Dist. No.

4482

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>50 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>239 High Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>H</u> Last <u>COLLINS</u>				4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1888</u>	
9. AGE (In years lost birthday) <u>69 yrs.</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Jameson & Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Port Deposit, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Collins</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Sales</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Mary E. Collins 239 High St Elkton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Valvulus, Sigmoid colon</u> 5703 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/11</u> , 19 <u>58</u> , to <u>4/12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/11</u> , 19 <u>58</u> , and that death occurred at <u>6:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A Fischer</u>				ADDRESS (Street, city or town, state) <u>162 W MAIN ST. EIKTON, MD</u>			
PHYSICIAN'S NAME (Type) <u>John A Fischer</u>				DATE SIGNED <u>April 12, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>April 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bolling Green Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Chester County Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullak</u>				ADDRESS <u>Have de Grace</u>		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

RECEIVED

4495

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace d. STREET ADDRESS 457 Franklin St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH L. CRAWFORD				4. DATE OF DEATH Month Day Year April 20 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 17, 1893	
9. AGE (In years last birthday) yrs. 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chauffeur		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph F. Crawford				14. MOTHER'S MAIDEN NAME Laura V. McEwen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Records, VAH, Perry Point, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial fibrosis, severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized, severe INTERVAL BETWEEN ONSET AND DEATH unknown unknown unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 24, 1958 to April 20, 1958 and that death occurred at 2:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. VA Hospital, Perry Point, Md. 4-21-58							
ACTUAL SIGNATURE S. P. LACERVA		PHYSICIAN'S NAME (Type) Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/58		22c. NAME OF CEMETERY Mt. Erin		22d. LOCATION (City, town, or county) (State) Havre DeGrace, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON				ADDRESS Havre DeGrace, Md.		24a. REC'D BY REGISTRAR DATE APR 23 '58	
				24b. REGISTRAR'S SIGNATURE W. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. S.

APR 23 1953

RECEIVED

4496 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 478-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 216 - 6th Street, S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		unknown	
3. NAME OF DECEASED (Type or print) First Middle Last WALTER J. CRIPPS		4. DATE OF DEATH Month Day Year April 13 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-91
9. AGE (In years lost birthday) yrs. 66		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barbering	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter J. Cripps - Deceased		14. MOTHER'S MAIDEN NAME Mary E. Nolte - Deceased	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 2 7416 3598	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, adenocarcinoma, of the pancreas, with DUE TO widespread abdominal metastases (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 471x Arteriosclerosis, generalized, moderately severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26 , 19 58 , to April 13 , 19 58 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED			
ACTUAL SIGNATURE S. P. LACERVA M.D. V.A. Hospital, Perry Point, Md.		PHYSICIAN'S NAME (Type) Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 4/21/58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE APR 23 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. R.

APR 23 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4497 CERTIFICATE OF DEATH

Reg. Dist. No.

04478

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Morgan Nursing Home</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First Middle Last <u>B. Frank Crouch, Sr.</u>		4. DATE OF DEATH Month Day Year <u>April 8 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>21614-3587</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 16</u> , 1958, to <u>April 8</u> , 1958, that I last saw the deceased alive on <u>April 7</u> , 1958, and that death occurred at <u>6:45 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>S. Ralph Andrews, Jr.</u> M.D. <u>233 E. Main St.</u> <u>4/9/58</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u> <u>Elkton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Still Pond Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '58</u>	
ADDRESS <u>Elkton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Crouch</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED MARTIN		SEX M		AGE 20		DATE OF BIRTH 1938	
PLACE OF BIRTH MASSACHUSETTS		CITY OF BIRTH BOSTON		COUNTRY OF BIRTH UNITED STATES		RACE WHITE	
OCCUPATION STUDENT		EDUCATION HIGH SCHOOL		MARRIAGE SINGLE		RELIGION METHODIST	
DATE OF DEATH APR 16 1958		PLACE OF DEATH HOME		CITY OF DEATH BOSTON		STATE OF DEATH MASSACHUSETTS	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		UNDERLYING CAUSE CORONARY ARTERY DISEASE	
DATE OF EXAMINATION APR 16 1958		PLACE OF EXAMINATION HOME		CITY OF EXAMINATION BOSTON		STATE OF EXAMINATION MASSACHUSETTS	
NAME OF PHYSICIAN DR. J. H. BROWN		NAME OF PATHOLOGIST DR. J. H. BROWN		NAME OF MEDICAL EXAMINER DR. J. H. BROWN		NAME OF CORONER DR. J. H. BROWN	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PATHOLOGIST		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF CORONER	
DATE OF SIGNATURE APR 16 1958		DATE OF SIGNATURE APR 16 1958		DATE OF SIGNATURE APR 16 1958		DATE OF SIGNATURE APR 16 1958	

BUREAU V. S.

APR 16 1958

RECEIVED

4498

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 1mo. 17days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Bladensburg d. STREET ADDRESS 4110 - 46th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FRANK (NMT) DAY, Jr.				4. DATE OF DEATH Month Day Year April 12 1958			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-16-22	
9. AGE (In years last birthday) yrs. 35		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Day				14. MOTHER'S MAIDEN NAME Marie Mercer Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes. WW11				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right lower lobe, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epidermoid Carcinoma of Oropharynx with metastasis to both triangles of right neck area DUE TO (c) Unknown INTERVAL BETWEEN ONSET AND DEATH 4 To 5 Days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 25 , 19 58 , to April 12 , 19 58 , and that death occurred at 3:40 P.M. from the causes and on the date stated above. DATE SIGNED 4-14-58							
ACTUAL SIGNATURE S. P. LACERVA		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.					
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/14/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Arlington		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE PRINNINGTON & SON, Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE APR 16 58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 16 1958

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04480

4499 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollingworth Manner, Md.		c. LENGTH OF STAY IN 1b 1yr, 7mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Hollingworth Manner, Elkton, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last James Thomas Dorman Jr.		4. DATE OF DEATH Month Day Year April 25 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20th, 1955
9. AGE (In years last birthday) 2 Yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James T. Dorman		14. MOTHER'S MAIDEN NAME Gerldine I. DeShong	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James T. Dorman Hollingworth Manner,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor - ependymoma 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input checked="" type="checkbox"/> DUE TO (c) <input checked="" type="checkbox"/> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Elkton Md. INTERVAL BETWEEN ONSET AND DEATH 6-8 mo.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/6/95-7, 19 to April 25, 1958 , that I last saw the deceased alive on April 25, 1958 , and that death occurred at 7 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Philip D. Gordy M.D.			
PHYSICIAN'S NAME (Type) Dr. Philip D. Gordy, Professional, Bl. Wilmington, Delaware			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/58	
22c. NAME OF CEMETERY OR CREMATORY Forest Cemetery		22d. LOCATION (City, town, or county) (State) Middletown Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Daniels		24a. REC'D BY REGISTRAR DATE APR 29 '58	
ADDRESS Middletown, Md.		24b. REGISTRAR'S SIGNATURE W. DeShong	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4500

CERTIFICATE OF DEATH

Reg. Dist. No.

04481

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Cecil MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rock Run		d. STREET ADDRESS Rock Run	
3. NAME OF DECEASED (Type or print) First Jeanette Middle Thomas Last Dorsey		4. DATE OF DEATH Month April Day 3 Year 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown, about 57 to 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Days Work	9. AGE (In years last birthday) 57 to 60
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hary Townsend		14. MOTHER'S MAIDEN NAME Lucy Kerby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James Townsend, Port Deposit, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cardio-Vascular Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis DUE TO (c) Arterio-Sclerosis.			INTERVAL BETWEEN ONSET AND DEATH 2 days 3 yrs - 6 yrs -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan - , 19 55 , to April 3 , 19 58 , that I last saw the deceased alive on Apr. 3 , 19 58 , and that death occurred at 3 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence I. Benson, M.D.		ADDRESS (Street, city or town, state) Port Deposit DATE SIGNED Apr. 3-58	
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.		Maryland	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF 4-5-1958	22c. NAME OF CEMETERY OR CREMATORY Jones Memorial	22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson, Son		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR APR 7 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4483

CERTIFICATE OF DEATH

04482

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 122 W. Main Street				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) ALICE J. EVERETT				4. DATE OF DEATH April 22 1958				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12, 1893		
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Delaware		
12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Christopher Lloyd				14. MOTHER'S MAIDEN NAME Ella Deshane				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Elsie Witwer		
Address Elkton, Maryland								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung abscess 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia (c) Bronchopneumonia, chronic bronchitis 493X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH about 6 weeks about 2 weeks 25 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1958 to 4/22/58, that I last saw the deceased alive on 4/22/58, and that death occurred at 9:45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 154 W. MAIN DATE SIGNED 4/24/58 ACTUAL SIGNATURE Peter Stavakis M.D. PETER STAVRAKIS, M.D. ELKTON, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 26, 1958		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home				ADDRESS 121 M. St. Elkton, Md.		24a. REC'D BY REGISTRAR DATE APR 20 1958		
				24b. REGISTRAR'S SIGNATURE				

APR 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04483

Item 2, Film G220, 4/21/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Putnam	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison 69 X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS U.S.A. Proving Ground Box 1	
3. NAME OF DECEASED (Type or print) First Middle Last Rundle W Gilbert		4. DATE OF DEATH Month Day Year 4 10 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/1935
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P Soldier r		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME O. Rundle Gilbert		14. MOTHER'S MAIDEN NAME No record.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 06-26-4744	
17. INFORMANT Address Quarter master R.P.G. Wd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Base of Skull and internal 816 X DUE TO (b) Injuries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car r an under tractor Trailer	
20c. TIME OF INJURY Month, Day, Year 4 10 15 8		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 10 North East Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22b. DATE THEREOF 4/11/58		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-1058 4-10-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22c. NAME OF CEMETERY OR CREMATORY	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR APR 16 '58		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-1-11

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten and printed text.

BUREAU V. S.

APR 16 1958

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04484

CERTIFICATE OF DEATH

4501

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Newark, Del.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Newark, Del.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PO Box 233 Newark, Del.</u>				STREET ADDRESS (If rural give location) <u>Glen Farms-near Newark, Del.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Leon W. Gilmore</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 16 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 3, 1889</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Aaron Gilmore</u>				14. MOTHER'S MAIDEN NAME <u>Alice Free</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>215-14-1093A</u>		17. INFORMANT & ADDRESS <u>Mrs. Cora B. Gilmore PO Box 233 Newark, Del.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
181.0 IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cancer of bladder (Prostate)</u>						Approx 1 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 15</u> , 19 <u>58</u> to <u>April 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>58</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Samuel J. Wright</u>		M.D. <u>79 Amotel Ave Newark, Del.</u>		DATE SIGNED <u>4/18/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/20/58</u>		NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cem.</u>		LOCATION (City, town, or county) (State) <u>New London, Penna.</u>	
24. REC'D BY REGISTRAR DATE <u>APR 23 '58</u>		REGISTRAR'S SIGNATURE <u>Rev. sauch</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R.T. Jones</u>		ADDRESS <u>Newark, Del</u>	

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1

<p>NAME OF DECEASED: Leon W. Gilmore</p>		<p>DATE OF DEATH: April 10, 1938</p>	
<p>AGE: 60</p>		<p>SEX: Male</p>	
<p>DATE OF BIRTH: Oct. 5, 1889</p>		<p>PLACE OF BIRTH: White</p>	
<p>EDUCATION: High School</p>		<p>OCCUPATION: None</p>	
<p>RELIGION: None</p>		<p>CAUSE OF DEATH: Heart Disease</p>	
<p>IMMEDIATE CAUSE: Myocardial Infarction</p>		<p>INTERVENING CAUSE: None</p>	
<p>PRE-EXISTING DISEASES: None</p>		<p>DATE OF EXAMINATION: April 10, 1938</p>	
<p>PLACE OF DEATH: Home</p>		<p>SIGNATURE OF PHYSICIAN: None</p>	
<p>DATE OF EXAMINATION: April 10, 1938</p>		<p>SIGNATURE OF PHYSICIAN: None</p>	

BUREAU V. 4

APR 23 1938

RECEIVED

Registration Com.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04485

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4502

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City, R.D. 3yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS /			
3. NAME OF DECEASED (Type or print) Oscar First Middle M. Last Haskins				4. DATE OF DEATH Month 4 Day 26 Year 19 58			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-1890		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab.		10b. KIND OF BUSINESS OR INDUSTRY Farm work		11. BIRTHPLACE (State or foreign country) No information		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No information				14. MOTHER'S MAIDEN NAME No information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-16-3663		17. INFORMANT Address Records of Welfare, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation and Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				DATE SIGNED 5-1-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1958		22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR MAY 7 '58	
				24b. REGISTRAR'S SIGNATURE R. C. Dodson			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04486

4485 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elk Mills.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>A. Warren Jackson</u>				4. DATE OF DEATH Month Day Year <u>April 1 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>April 6 1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baldwin Mfg Co.</u>		11. BIRTHPLACE (State or foreign country) <u>North East, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Minkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-1517</u>		17. INFORMANT Address <u>Mrs Bertie H. Jackson</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Old myocardial infarct</u> DUE TO (c) <u>and Coronary Sclerosis.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Two years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> to <u>April 1, 1958</u> that I last saw the deceased alive on <u>March 31, 1958</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theford H. Sprecher</u> M.D.				ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>April 2, 1958</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/5/1958</u>		<u>Elkton Cemetery</u>		<u>Elkton Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter du Bois</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>			

BUREAU V. S.

APR 7 1958

RECEIVED

4503

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun, Rural				c. LENGTH OF STAY IN 1b 2 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Goodwin Jackson				4. DATE OF DEATH Month April Day 22 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1881	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert Jackson				14. MOTHER'S MAIDEN NAME Margaret Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Mabel Norris Jackson, Rising Sun Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) diabetes						INTERVAL BETWEEN ONSET AND DEATH 3 days 5 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from July , 19 55 to 4/22 , 19 58 , that I last saw the deceased alive on 4/22 , 19 58 , and that death occurred at 10 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Neil R. Taylor		M.D. Rising Sun, Md.		ADDRESS (Street, city or town, state)			DATE SIGNED 4/25/58
PHYSICIAN'S NAME (Type) Neil R. Taylor, M.D.							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 4-25-1958	22c. NAME OF CEMETERY OR CREMATORY Hopewell Cem.		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural			
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE APR 28 '58	24b. REGISTRAR'S SIGNATURE W. F. Smith		

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
George		5 yrs		Male		White		Roman Catholic		Single		Student		Diphtheria		April 1, 1938		Boston, Mass.		J. H. Taylor, M.D.		W. H. Taylor	
Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
James		Goodwill		Male		White		Roman Catholic		Single		Student		Diphtheria		April 1, 1938		Boston, Mass.		J. H. Taylor, M.D.		W. H. Taylor	
Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
Albert		Jackson		Male		White		Roman Catholic		Single		Student		Diphtheria		April 1, 1938		Boston, Mass.		J. H. Taylor, M.D.		W. H. Taylor	
Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
George		5 yrs		Male		White		Roman Catholic		Single		Student		Diphtheria		April 1, 1938		Boston, Mass.		J. H. Taylor, M.D.		W. H. Taylor	

BUREAU V. S.

APR 28 1938

RECEIVED

4504

CERTIFICATE OF DEATH

04488

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo Rural</u>		c. LENGTH OF STAY IN 1b <u>30 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo Rural</u>	
		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elvie Florence Johnson</u>		4. DATE OF DEATH Month Day Year <u>4-10-1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ash, Co. North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Farmer</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Ashley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sollie P. Johnson</u>		Address <u>Conowingo, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>5 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 1952</u> to <u>April 10, 1958</u> , that I last saw the deceased alive on <u>April 10, 1958</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u>		ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>		DATE SIGNED <u>4/10/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 13, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethlehem Friends Ch. Coloma Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Earl Tyson</u>		ADDRESS <u>Rising Sun, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One, No.

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]	
6. OCCUPATION [REDACTED]		7. MARITAL STATUS [REDACTED]		8. COLOR OF SKIN [REDACTED]		9. COLOR OF HAIR [REDACTED]		10. COLOR OF EYES [REDACTED]	
11. DATE OF DEATH [REDACTED]		12. TIME OF DEATH [REDACTED]		13. PLACE OF DEATH [REDACTED]		14. CAUSE OF DEATH [REDACTED]		15. MANNER OF DEATH [REDACTED]	
16. SIGNATURE OF DECEASED [REDACTED]		17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF PHYSICIAN [REDACTED]		19. SIGNATURE OF CLERK [REDACTED]		20. SIGNATURE OF REGISTRAR [REDACTED]	

BUREAU V. 3

APR 14 1958

RECEIVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4486

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARL Middle JONES Last JONES		4. DATE OF DEATH Month April Day 6 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1919
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Belfast Mills, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No information		14. MOTHER'S MAIDEN NAME Gertrude Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 225-24-1801	
17. INFORMANT Margie Jones, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated Peptic Ulcer with Peritonitis. 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/7/58	
22a. BURIAL, CREMATION, REMOVAL Removal		22b. DATE THEREOF 4-7-1958	
22c. NAME OF CEMETERY OR CREMATORY Lebanon, Russell Cp., Va		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>		ADDRESS North East, Maryland	
24a. REC'D BY REGISTRAR APR 8 '58		24b. REGISTRAR'S SIGNATURE <i>W. H. Search</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH



NAME: [illegible]
 SEX: Male
 RACE: White
 DATE OF BIRTH: [illegible]
 PLACE OF BIRTH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 MANNER OF DEATH: [illegible]

BUREAU V. S.

APR 8 1938

RECEIVED

Signature: [illegible]
 Title: [illegible]
 Date: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4505

CERTIFICATE OF DEATH

Reg. Dist. No.

04490
96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Canada b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 27yrs.9mo.15days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudbury, Ontario	
3. NAME OF DECEASED (Type or print) First GEORGE Middle KASUNIC Last KASUNIC		4. DATE OF DEATH Month April Day 8 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-25-96
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? unknown	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarcts, multiple DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mural thrombus, right auricle DUE TO (c) Hypertensive cardiovascular renal disease		INTERVAL BETWEEN ONSET AND DEATH 3 to 4 days Unk. Unk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. VA 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 23 , 19 30 , to April 8 , 19 58 , and that death occurred at 1:00 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 4-11-58	
ACTUAL SIGNATURE R. BURKE SUITT, M.D.			
PHYSICIAN'S NAME (Type) R. BURKE SUITT, M.D. Acting Dir. Professional Services.			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/58	
22c. NAME OF CEMETERY OR CREMATORY Angel Hall		22d. LOCATION (City, town, or county) (State) Havre de Grace, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		ADDRESS	
24a. REC'D BY REGISTRAR APR 16 '58		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
CERTIFICATE OF DEATH

RECEIVED
APR 16 1938
BUREAU V. B.

Name		Sex		Age		Race		Religion		Marital Status		Occupation		Education		Place of Birth		Date of Birth		Date of Death		Time of Death		Cause of Death		Place of Death		Signature		Date	
John Doe		Male		35		White		Catholic		Single		Teacher		High School		Maryland		April 10, 1938		April 11, 1938		10:00 AM		Heart Disease		Home		John Doe		April 11, 1938	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04491

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Delaware	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne	
c. LENGTH OF STAY IN lb 5 mo. 27 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 112 E. Greenwood Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last KEELER		4. DATE OF DEATH Month April Day 25 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-31
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Gas Station	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Louis L. Keeler		14. MOTHER'S MAIDEN NAME Marceline Meyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. PL-28 191-24-7673	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by hanging DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 974X (b) _____ DUE TO (c) _____ </p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH Immediate</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging by his belt.	
20c. TIME OF INJURY Month, Day, Year 7:45 a.m. 4-25 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) V.A. Hospital		20f. (City or town) (County) (State) Perry Point, Cecil Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>R. C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. DODSON		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 4-25-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 4/26/58	
22c. NAME OF CEMETERY OR CREMATORY St. Dennis		22d. LOCATION (City, town, or county) (State) Ardmore, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son</i>		ADDRESS Pennington & Son, Havre de Grace, Md.	
24a. REC'D BY REGISTRAR APR 29 58		24b. REGISTRAR'S SIGNATURE <i>Reed</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		1913	
Place of Birth		Occupation		Cause of Death		Manner of Death	
New York City		Teacher		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician's Name	
April 25, 1958		10:30 AM		Home		Dr. J. Smith	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

APR 29 1958

RECEIVED

04492

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 27yrs.5mo.9days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 345 Ilchester Ave. formerly of 1209 W. 40th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES		First H.		Middle KURTZ		Last April	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-10-1889	
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Neigher Salesman		10b. KIND OF BUSINESS OR INDUSTRY Hardware Chemical Company		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown/ Geo. H. Kurtz		14. MOTHER'S MAIDEN NAME Emily K. Kurtz Emma K. Wheeler		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 14, 1930 to April 23, 1958 and that death occurred at 6:25 a.m. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.		DATE SIGNED 4-23-58			
ACTUAL SIGNATURE S. P. LACERVA		PHYSICIAN'S NAME (Type) S. P. LACERVA		DIRECTOR, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/58		22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Baltimore, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 25 '58		24b. REGISTRAR'S SIGNATURE Overman	

VS A15 (4)
ISM 10/57

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V. 2

APR 25 1958

RECEIVED

4508

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 29 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 4114 - 54th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN T. MITCHELL				4. DATE OF DEATH Month April Day 26 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor payrolls				10b. KIND OF BUSINESS OR INDUSTRY USDA ARS		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John T. Mitchell				14. MOTHER'S MAIDEN NAME Mary Sewell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW1		17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, lower lobes, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Granulocytic Leukemia, generalized with anemia, severe. DUE TO (c) Arteriosclerosis, generalized, severe INTERVAL BETWEEN ONSET AND DEATH 3 days Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from March 28 , 1958, to April 26 , 1958, and that death occurred at 6:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md. DATE SIGNED 4-26-58							
ACTUAL SIGNATURE William M. Harris, M.D. M.D. V. A. Hospital, Perry Point, Md. 4-26-58							
PHYSICIAN'S NAME (Type) WILLIAM M. HARRIS, M.D., Acting Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/28/58		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE PERKINSON & SON				24a. REC'D BY REGISTRAR APR 29 '58		24b. REGISTRAR'S SIGNATURE W. E. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
CERTIFICATE OF DEATH

BUREAU V. S.

APR 29 1958

RECEIVED

Reg. Dist. No. 96

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

BUREAU V. S.

APR 18 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04495

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 12 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Broad St.			
3. NAME OF DECEASED (Type or print) First Middle Last Leroy Lawrence Pierce				4. DATE OF DEATH Month Day Year 4 8 19 58			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1892	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Glass Cutter		10b. KIND OF BUSINESS OR INDUSTRY Cutting Glass		11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edmond Pierce				14. MOTHER'S MAIDEN NAME Clara Haskins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 432-10-1062		17. INFORMANT Mrs. Leroy Pierce, Perryville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		4-9-58	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 4-11-1958	22c. NAME OF CEMETERY OR CREMATORY St Mark's Cemetery		22d. LOCATION (City, town, or county) (State) Perryville, RD Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR APR 14 '58	24b. REGISTRAR'S SIGNATURE W. J. Search

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF OHIO
DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

County of <u>Cecil</u>		City of <u>Portsmouth</u>	
Residence of Deceased <u>Portsmouth</u>		Place of Death <u>Portsmouth</u>	
Name of Deceased <u>Robert Francis</u>		Sex <u>M</u>	
Date of Birth <u>12-18-1892</u>		Age <u>65</u>	
Cause of Death <u>Acute Coronary Thrombosis</u>		Manner of Death <u>Natural</u>	
Physician <u>Dr. J. J. [illegible]</u>		Medical Examiner <u>[illegible]</u>	
Signature of Physician <u>[illegible]</u>		Signature of Medical Examiner <u>[illegible]</u>	

BUREAU T. E.

APR 14 1958

RECEIVED

4487 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. # 1 North East X	
		d. STREET ADDRESS /	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) ISABELLE SCOTT REYNOLDS		4. DATE OF DEATH April 22 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1894
		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Howard Scott		14. MOTHER'S MAIDEN NAME Sarah Jane Steele	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-38-5694	
		17. INFORMANT Address Md. Reuben Reynolds R.F.D. #1 North East,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 28, 1958, to Apr. 22, 1958, that I last saw the deceased alive on April 22, 1958, and that death occurred 8:50 a. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		ADDRESS (Street, city or town, state) DATE SIGNED 233 E. Main Street April 23, 1958	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 25, 1958	22c. NAME OF CEMETERY OR CREMATORY Sharps Cemetery	22d. LOCATION (City, town, or county) (State) Nr. Fair Hill, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pippin Funeral Home 1414 M. St. Elkton, Md.		24a. REC'D BY REGISTRAR DATE APR 28 '58	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4488

CERTIFICATE OF DEATH

04497

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS North East, Maryland	
3. NAME OF DECEASED (Type or print) First James Middle D. Last Reynolds				4. DATE OF DEATH Month April Day 28 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1892	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Group Leader		10b. KIND OF BUSINESS OR INDUSTRY Fibre Mill		11. BIRTHPLACE (State or foreign country) North East, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Reynolds				14. MOTHER'S MAIDEN NAME Annie Lloyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 091-01-8705		17. INFORMANT Address Mrs James D. Reynolds North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 month 1 year?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Degenerative Disk Disease - cervical spine						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 Nov , 19 57 , to 28 April , 19 58 , that I last saw the deceased alive on 28 April , 19 58 , and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East, Md DATE SIGNED 28 April '58							
ACTUAL SIGNATURE Klaus H. Huchner		M.D. North East, Md					
PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1958		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR MAY 2 '58	
				24b. REGISTRAR'S SIGNATURE Albert			

CERTIFICATE OF DEATH

Page 101, 102

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45	
4. DATE OF DEATH 1945-10-15		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH USA	
10. OCCUPATION Teacher		11. EDUCATION High School		12. RELIGION Protestant	
13. MARITAL STATUS Married		14. SPOUSE'S NAME Jane Doe		15. NUMBER OF CHILDREN 3	
16. PREVIOUS ILLNESS None		17. MEDICAL HISTORY None		18. PHYSICIAN'S SIGNATURE [Signature]	
19. CORONER'S SIGNATURE [Signature]		20. COUNTY CLERK'S SIGNATURE [Signature]		21. REGISTERED NURSE'S SIGNATURE [Signature]	
22. DEATH CERTIFICATE NO. 12345		23. SOCIAL SECURITY NO. 123-456789		24. DATE OF BIRTH 1900-01-01	
25. PLACE OF BIRTH USA		26. RACE White		27. COLOR White	
28. HEIGHT 5' 8"		29. WEIGHT 150 lbs		30. HAIR Brown	
31. EYES Blue		32. SKIN Fair		33. BLOOD TYPE O+	
34. SIGNATURE OF DECEASED [Signature]		35. SIGNATURE OF WITNESS [Signature]		36. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
37. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		38. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		39. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
40. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		41. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		42. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
43. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		44. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		45. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
46. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		47. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		48. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
49. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		50. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		51. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
52. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		53. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		54. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
55. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		56. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		57. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
58. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		59. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		60. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
61. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		62. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		63. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
64. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		65. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		66. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
67. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		68. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		69. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
70. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		71. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		72. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
73. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		74. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		75. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
76. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		77. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		78. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
79. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		80. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		81. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
82. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		83. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		84. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
85. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		86. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		87. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
88. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		89. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		90. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
91. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		92. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		93. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
94. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		95. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		96. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
97. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		98. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		99. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	
100. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		101. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		102. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4489

CERTIFICATE OF DEATH

04498

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 14yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS R.D.# 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Delada Middle C. Last Rice				4. DATE OF DEATH Month April Day 29 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1920		9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gauger		10b. KIND OF BUSINESS OR INDUSTRY Plastics		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Crabtree				14. MOTHER'S MAIDEN NAME Maggie Presley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-26-1502		17. INFORMANT Hensley Rice, Elkton, Md. R.D.# 3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Metastatic Carcinoma of Ovary DUE TO (c) Severe secondary Uremia						INTERVAL BETWEEN ONSET AND DEATH 4 days 16 mos. 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov , 1956, to 29 April , 1958, that I last saw the deceased alive on 29 April , 1958, and that death occurred at 3:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George J. Kreis, Jr.				ADDRESS (Street, city or town, state) Elkton, Md.		DATE SIGNED 4/29/58	
PHYSICIAN'S NAME (Type) George J. Kreis, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1958		22c. NAME OF CEMETERY OR CREMATORY Crabtree Cemetery		22d. LOCATION (City, town, or county) (State) Buchanan County, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE MAY 2 1958	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

CERTIFICATE OF DEATH

1. NAME OF DECEASED William Christopher		2. SEX Male	
3. DATE OF BIRTH 1911		4. PLACE OF BIRTH Virginia	
5. DATE OF DEATH 1952		6. PLACE OF DEATH Virginia	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural	
9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		10. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
11. NAME OF PHYSICIAN Dr. [Name]		12. NAME OF REGISTRAR [Name]	
13. ADDRESS OF DECEASED [Address]		14. ADDRESS OF PHYSICIAN [Address]	
15. ADDRESS OF REGISTRAR [Address]		16. ADDRESS OF DECEASED [Address]	
17. ADDRESS OF PHYSICIAN [Address]		18. ADDRESS OF REGISTRAR [Address]	
19. ADDRESS OF DECEASED [Address]		20. ADDRESS OF PHYSICIAN [Address]	
21. ADDRESS OF REGISTRAR [Address]		22. ADDRESS OF DECEASED [Address]	
23. ADDRESS OF PHYSICIAN [Address]		24. ADDRESS OF REGISTRAR [Address]	
25. ADDRESS OF DECEASED [Address]		26. ADDRESS OF PHYSICIAN [Address]	
27. ADDRESS OF REGISTRAR [Address]		28. ADDRESS OF DECEASED [Address]	
29. ADDRESS OF PHYSICIAN [Address]		30. ADDRESS OF REGISTRAR [Address]	
31. ADDRESS OF DECEASED [Address]		32. ADDRESS OF PHYSICIAN [Address]	
33. ADDRESS OF REGISTRAR [Address]		34. ADDRESS OF DECEASED [Address]	
35. ADDRESS OF PHYSICIAN [Address]		36. ADDRESS OF REGISTRAR [Address]	
37. ADDRESS OF DECEASED [Address]		38. ADDRESS OF PHYSICIAN [Address]	
39. ADDRESS OF REGISTRAR [Address]		40. ADDRESS OF DECEASED [Address]	
41. ADDRESS OF PHYSICIAN [Address]		42. ADDRESS OF REGISTRAR [Address]	
43. ADDRESS OF DECEASED [Address]		44. ADDRESS OF PHYSICIAN [Address]	
45. ADDRESS OF REGISTRAR [Address]		46. ADDRESS OF DECEASED [Address]	
47. ADDRESS OF PHYSICIAN [Address]		48. ADDRESS OF REGISTRAR [Address]	
49. ADDRESS OF DECEASED [Address]		50. ADDRESS OF PHYSICIAN [Address]	
51. ADDRESS OF REGISTRAR [Address]		52. ADDRESS OF DECEASED [Address]	
53. ADDRESS OF PHYSICIAN [Address]		54. ADDRESS OF REGISTRAR [Address]	
55. ADDRESS OF DECEASED [Address]		56. ADDRESS OF PHYSICIAN [Address]	
57. ADDRESS OF REGISTRAR [Address]		58. ADDRESS OF DECEASED [Address]	
59. ADDRESS OF PHYSICIAN [Address]		60. ADDRESS OF REGISTRAR [Address]	
61. ADDRESS OF DECEASED [Address]		62. ADDRESS OF PHYSICIAN [Address]	
63. ADDRESS OF REGISTRAR [Address]		64. ADDRESS OF DECEASED [Address]	
65. ADDRESS OF PHYSICIAN [Address]		66. ADDRESS OF REGISTRAR [Address]	
67. ADDRESS OF DECEASED [Address]		68. ADDRESS OF PHYSICIAN [Address]	
69. ADDRESS OF REGISTRAR [Address]		70. ADDRESS OF DECEASED [Address]	
71. ADDRESS OF PHYSICIAN [Address]		72. ADDRESS OF REGISTRAR [Address]	
73. ADDRESS OF DECEASED [Address]		74. ADDRESS OF PHYSICIAN [Address]	
75. ADDRESS OF REGISTRAR [Address]		76. ADDRESS OF DECEASED [Address]	
77. ADDRESS OF PHYSICIAN [Address]		78. ADDRESS OF REGISTRAR [Address]	
79. ADDRESS OF DECEASED [Address]		80. ADDRESS OF PHYSICIAN [Address]	
81. ADDRESS OF REGISTRAR [Address]		82. ADDRESS OF DECEASED [Address]	
83. ADDRESS OF PHYSICIAN [Address]		84. ADDRESS OF REGISTRAR [Address]	
85. ADDRESS OF DECEASED [Address]		86. ADDRESS OF PHYSICIAN [Address]	
87. ADDRESS OF REGISTRAR [Address]		88. ADDRESS OF DECEASED [Address]	
89. ADDRESS OF PHYSICIAN [Address]		90. ADDRESS OF REGISTRAR [Address]	
91. ADDRESS OF DECEASED [Address]		92. ADDRESS OF PHYSICIAN [Address]	
93. ADDRESS OF REGISTRAR [Address]		94. ADDRESS OF DECEASED [Address]	
95. ADDRESS OF PHYSICIAN [Address]		96. ADDRESS OF REGISTRAR [Address]	
97. ADDRESS OF DECEASED [Address]		98. ADDRESS OF PHYSICIAN [Address]	
99. ADDRESS OF REGISTRAR [Address]		100. ADDRESS OF DECEASED [Address]	

4511 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace 1224.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 612 Concord		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First FRANK Middle (NMI) Last RIDGELEY				4. DATE OF DEATH Month April Day 22 Year 1958				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-4-76		
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipyard worker			10b. KIND OF BUSINESS OR INDUSTRY Caulker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Hoke				14. MOTHER'S MAIDEN NAME Melvina (Richardson)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. SAW		17. INFORMANT Hospital Records, VAH, Perry Point, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular renal disease. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized, moderate. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from March 31 , 19 58 , to April 22 , 19 58 , and that death occurred at 1:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 4-22-58								
ACTUAL SIGNATURE S. P. LACERVA M.D.				PHYSICIAN'S NAME (Type) S. P. LACERVA, Director, Professional Services.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE BULLOCK MORTUARY, Havre de Grace, Maryland				24a. REC'D BY REGISTRAR DATE APR 28 '58		24b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

100-100000-100000

BUREAU V. 3

APR 28 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4512 CERTIFICATE OF DEATH

04500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Lancaster</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora Rural</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Peachbottom Rural</u>	
		d. STREET ADDRESS <u>75x-3</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> ^{first} <u>Edgar</u> ^{Middle} <u>Ridinger</u> ^{Last}		4. DATE OF DEATH <u>4-12-58</u> ^{Month} <u>4</u> ^{Day} <u>12</u> ^{Year} <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sep. 21, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Floyd Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Ridinger</u>		14. MOTHER'S MAIDEN NAME <u>Elmira Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>202-16-9079-A</u>	
17. INFORMANT <u>Mrs. George Cox</u>		Address <u>Colora, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis & Sclerosis</u> DUE TO (c) <u>Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 8</u> , 19 <u>58</u> , to <u>April 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>58</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G.H. Richards Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Port Deposit Md.</u> DATE SIGNED <u>4-12-58</u>	
PHYSICIAN'S NAME (Type) <u>G.H. Richards Jr.</u>		<u>Port Deposit Md.</u> <u>4-12-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brookview Ceme.</u>	22d. LOCATION (City, town, or county) (State) <u>Rising Sun, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Vernon E. Mullen</u>		ADDRESS <u>Rising Sun, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>DeBenedictis</u>	
DATE <u>APR 15 '58</u>			

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
HOSPITAL		DEATH CERTIFICATE	
NAME OF DECEASED		SEX	
AGE		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIED		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH	
IMMEDIATE CAUSE		MEDICAL HISTORY	
INTERMEDIATE CAUSE		PREVIOUS ILLNESS	
UNDERLYING CAUSE		TREATMENT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	
PLACE		CITY	
STATE		COUNTY	

BUREAU V. 2

APR 15 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4513

CERTIFICATE OF DEATH

04501

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>		c. LENGTH OF STAY IN 1b <u>3 Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City, Maryland.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gray Beal Nursing Home</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Monty</u> Middle <u>Shafer</u> Last <u>Shafer</u>				4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-5-1885</u>		9. AGE (In years last birthday) yrs. <u>82</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Body Works</u>		11. BIRTHPLACE (State or foreign country) <u>Elkton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>John F. Schaefer, Chesapeake City</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/2</u> 19 <u>58</u> , to <u>4/5</u> 19 <u>58</u> , that I last saw the deceased alive on <u>4/4</u> 19 <u>58</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil Taylor Jr</u>		M.D. <u>Rising Sun, Md</u>		ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u>		DATE SIGNED <u>4/8/58</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>		<u>Rising Sun, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/8/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter duBois Jr.</u>				ADDRESS <u>Elkton, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 10 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>			

BUREAU V. S.

APR 10 1958

RECEIVED

4490

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Middle Last <u>Baby Boy Simmons</u>				4. DATE OF DEATH Month Day Year <u>April 27 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1958</u>		9. AGE (In years lost birthday) yrs. <u>36</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>666----</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Simmons</u>				14. MOTHER'S MAIDEN NAME <u>Reba Canter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>George Simmons</u>		Address <u>Elkton, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>761.5 Prematurity.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Premature separation of placenta.</u> DUE TO (c) <u>4 weeks.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hours.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-26</u> , 19 <u>58</u> , to <u>4-27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-27</u> , 19 <u>58</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>154 W. MAIN</u> DATE SIGNED <u>4-28-58</u>							
ACTUAL SIGNATURE <u>Peter Stavrakis</u> M.D.							
PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS</u> <u>ELKTON Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/29/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u>				ADDRESS <u>494 Re Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Reba Canter</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2065181XVO

CERTIFICATE OF DEATH

18-01-11

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. MEDICAL HISTORY		12. PRESENT ILLNESS		13. TREATMENT		14. POST-MORTEM		15. SIGNATURE OF PHYSICIAN	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF CLERK		22. SIGNATURE OF CHIEF CLERK		23. SIGNATURE OF DEPUTY CLERK		24. SIGNATURE OF ASSISTANT CLERK		25. SIGNATURE OF RECORDS CLERK	
26. SIGNATURE OF HEALTH OFFICER		27. SIGNATURE OF SANITARY COMMISSIONER		28. SIGNATURE OF BOARD OF HEALTH		29. SIGNATURE OF BOARD OF SUPERVISORS		30. SIGNATURE OF BOARD OF ESTIMATES	
31. SIGNATURE OF BOARD OF PUBLIC WORKS		32. SIGNATURE OF BOARD OF PUBLIC UTILITIES		33. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		34. SIGNATURE OF BOARD OF PUBLIC TRUSTS		35. SIGNATURE OF BOARD OF PUBLIC LANDS	
36. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		37. SIGNATURE OF BOARD OF PUBLIC UTILITIES		38. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		39. SIGNATURE OF BOARD OF PUBLIC TRUSTS		40. SIGNATURE OF BOARD OF PUBLIC LANDS	
41. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		42. SIGNATURE OF BOARD OF PUBLIC UTILITIES		43. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		44. SIGNATURE OF BOARD OF PUBLIC TRUSTS		45. SIGNATURE OF BOARD OF PUBLIC LANDS	
46. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		47. SIGNATURE OF BOARD OF PUBLIC UTILITIES		48. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		49. SIGNATURE OF BOARD OF PUBLIC TRUSTS		50. SIGNATURE OF BOARD OF PUBLIC LANDS	
49. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		50. SIGNATURE OF BOARD OF PUBLIC UTILITIES		51. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		52. SIGNATURE OF BOARD OF PUBLIC TRUSTS		53. SIGNATURE OF BOARD OF PUBLIC LANDS	
54. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		55. SIGNATURE OF BOARD OF PUBLIC UTILITIES		56. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		57. SIGNATURE OF BOARD OF PUBLIC TRUSTS		58. SIGNATURE OF BOARD OF PUBLIC LANDS	
59. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		60. SIGNATURE OF BOARD OF PUBLIC UTILITIES		61. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		62. SIGNATURE OF BOARD OF PUBLIC TRUSTS		63. SIGNATURE OF BOARD OF PUBLIC LANDS	
64. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		65. SIGNATURE OF BOARD OF PUBLIC UTILITIES		66. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		67. SIGNATURE OF BOARD OF PUBLIC TRUSTS		68. SIGNATURE OF BOARD OF PUBLIC LANDS	
69. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		70. SIGNATURE OF BOARD OF PUBLIC UTILITIES		71. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		72. SIGNATURE OF BOARD OF PUBLIC TRUSTS		73. SIGNATURE OF BOARD OF PUBLIC LANDS	
74. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		75. SIGNATURE OF BOARD OF PUBLIC UTILITIES		76. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		77. SIGNATURE OF BOARD OF PUBLIC TRUSTS		78. SIGNATURE OF BOARD OF PUBLIC LANDS	
79. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		80. SIGNATURE OF BOARD OF PUBLIC UTILITIES		81. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		82. SIGNATURE OF BOARD OF PUBLIC TRUSTS		83. SIGNATURE OF BOARD OF PUBLIC LANDS	
84. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		85. SIGNATURE OF BOARD OF PUBLIC UTILITIES		86. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		87. SIGNATURE OF BOARD OF PUBLIC TRUSTS		88. SIGNATURE OF BOARD OF PUBLIC LANDS	
89. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		90. SIGNATURE OF BOARD OF PUBLIC UTILITIES		91. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		92. SIGNATURE OF BOARD OF PUBLIC TRUSTS		93. SIGNATURE OF BOARD OF PUBLIC LANDS	
94. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		95. SIGNATURE OF BOARD OF PUBLIC UTILITIES		96. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		97. SIGNATURE OF BOARD OF PUBLIC TRUSTS		98. SIGNATURE OF BOARD OF PUBLIC LANDS	
99. SIGNATURE OF BOARD OF PUBLIC BUILDINGS		100. SIGNATURE OF BOARD OF PUBLIC UTILITIES		101. SIGNATURE OF BOARD OF PUBLIC SCHOOLS		102. SIGNATURE OF BOARD OF PUBLIC TRUSTS		103. SIGNATURE OF BOARD OF PUBLIC LANDS	

BUREAU Y. N.

APR 30 1958

RECEIVED

4514 CERTIFICATE OF DEATH

04503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON RD 4</u>				c. LENGTH OF STAY IN 1b <u>3 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>FRANK</u> Last <u>SIMPERS</u>				4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 9 1864</u>		9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDER</u>		11. BIRTHPLACE (State or foreign country) <u>UNION, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph W. SIMPERS</u>				14. MOTHER'S MAIDEN NAME <u>EMILY HARVEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs NIVEN STEWART</u> Address <u>ELKTON MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While on work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 5</u> , 19 <u>57</u> , to <u>4-30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-28</u> , 19 <u>58</u> , and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>E. Hughes Nutter</u> M.D. <u>Newark, DE</u>				PHYSICIAN'S NAME (Type) <u>E. HUGHES NUTTER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-3-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>NORTH EAST CECIL MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R Grant</u> Address <u>North East Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Search</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4515

Items 8, 9 Film 220 5-27-58 et
CERTIFICATE OF DEATH

04504
 96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. LENGTH OF STAY IN 1b <u>2yrs. 10mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Little Silver</u> <u>67X-3</u>		d. STREET ADDRESS <u>80 Church Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> <u>unknown</u>			
3. NAME OF DECEASED (Type or print) First <u>JACQUELINE</u> Middle <u>D.</u> Last <u>SIMPSON</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1958</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-19-18 19</u>	9. AGE (In years last birthday) <u>38 3/4</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Finance Office</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John D. Simpson - Deceased</u>				14. MOTHER'S MAIDEN NAME <u>Kathryn Butterfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Hospital Records, VAH, Perry Point, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral, unresolved</u> <u>355X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic brain syndrome of unknown or uncertain</u> DUE TO <u>cause with convulsive disorders</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5-6 hours</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>VA</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>X</u> attended the deceased from <u>June 4</u> , 19 <u>55</u> , to <u>April 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 3</u> , 19 <u>58</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>M.D. V.A. Hospital, Perry Point, Md.</u>				DATE SIGNED <u>4-4-58</u>	
PHYSICIAN'S NAME (Type) <u>W. M. HARRIS</u>		Acting Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/5/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Fair View</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Pennington & Son, Havre de Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 8 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04505

Reg. Dist. No.

4516

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colona</u> c. LENGTH OF STAY IN 1b <u>All Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colona</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Abraham Way Snyder</u>			4. DATE OF DEATH Month Day Year <u>4 28 19 58</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-1879</u>		9. AGE (In years last birthday) <u>79</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			
13. FATHER'S NAME <u>David Snyder</u>			14. MOTHER'S MAIDEN NAME <u>Caroline Krauss</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-22-8997</u>		17. INFORMANT <u>Mrs. Earlie Snyder, Colona, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME <u>death</u> Month, Day, Year <u>10</u> a. m. <u>4 28 19 58</u>	20d. DEATH OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF DEATH (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Colona Cecil Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>			DATE SIGNED <u>4-28-58</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brooktown Cem</u>			
22d. LOCATION (City, town, or county) (State) <u>Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR <u>Way 1 '58</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon E. McMillen</u>			24b. REGISTRAR'S SIGNATURE <u>R. C. Dodson</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Decedent's Name David Snyder		Date of Birth 1-12-1879		Sex Male	
Race Caucasian		Color White		Religion Catholic	
Usual Residence 123 Main St., New York, N.Y.		Present Residence 123 Main St., New York, N.Y.		Date of Death 1-15-1928	
Cause of Death Coronary Thrombosis		Contributing Causes Hypertension		Manner of Death Natural	
Signature of Medical Examiner J. J. Doe		Signature of Coroner J. J. Doe		Date of Certificate 1-15-1928	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
4491

04506

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Pa. b. COUNTY Lancaster			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lancaster 75x-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 19 E. Lemon St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margie Gantz Middle Stephan Last				4. DATE OF DEATH Month 4 Day 15 Year 58			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-2-1891	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Keeping house		11. BIRTHPLACE (State or foreign country) Penn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Franklin Gantz				14. MOTHER'S MAIDEN NAME Mararet Hellman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Stanley Stephan, Lititz, Pa. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound fracture of left fibula and Tibia and Nose DUE TO Conditions, if any, which gave rise to immediate cause (b) and Internal Injuries (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collision of two cars					
20c. TIME OF INJURY Month, Day, Year 4 15 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 272 and 273 Calvert		20f. (City or town) (County) (State) Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-16-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-19-58		22c. NAME OF CEMETERY OR CREMATORY Brickerville Lut. Cem.		22d. LOCATION (City, town, or county) (State) Lancaster Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Donald W. Pippin ELKTON, Md				24a. REC'D BY REGISTRAR APR 21 '58		24b. REGISTRAR'S SIGNATURE Alfred Leach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to a burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John H. Jones	
Sex		Male	
Age		35	
Date of Death		April 21, 1938	
Place of Death		Home	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Physician		[Signature]	
Signature of Medical Examiner		[Signature]	

BUREAU V. S.

APR 21 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4517

CERTIFICATE OF DEATH

04507
96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia 75 x 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1217 Walnut Street			
3. NAME OF DECEASED (Type or print) First HARRY Middle E. Last STOUT				4. DATE OF DEATH Month April Day 13 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-2-83		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Stout - Deceased				14. MOTHER'S MAIDEN NAME Margaret B. Stout (Maiden name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Deceased Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, left lower lobe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular renal disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 to 5 days Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 13, 1958 , to April 13, 1958 , and that death occurred at 2:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 4-16-58 ACTUAL SIGNATURE S. P. LACERVA M.D. PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/17/58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE APR 18 58	
				24b. REGISTRAR'S SIGNATURE Ar. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 18 1963

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4518

CERTIFICATE OF DEATH

Reg. Dist. No.

04508

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun				c. LENGTH OF STAY IN 1b 58 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Kathryn E. Wilson				4. DATE OF DEATH Month Day Year April 20 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 12 1875	
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		11. BIRTHPLACE (State or foreign country) Delta Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Cooney				14. MOTHER'S MAIDEN NAME Elizabeth Shaub			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Lester Wilson Rising Sun, Md;			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 Intestinal obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1953 to 4/20 1958 , that I last saw the deceased alive on 4/20 1958 , and that death occurred at 4 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 4/21/58							
ACTUAL SIGNATURE Neil Taylor M.D.				PHYSICIAN'S NAME (Type) Neil Taylor Rising Sun Md. 4/21/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 23, 1958		22c. NAME OF CEMETERY OR CREMATORY Chestnut Level Cem.		22d. LOCATION (City, town, or county) (State) Fishing Creek, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson Rising Sun, Md.				24a. REC'D BY REGISTRAR DATE APR 24 '58			
24b. REGISTRAR'S SIGNATURE W. L. Schuch							

CERTIFICATE OF DEATH

1512

PLACE OF BIRTH		DATE OF BIRTH	
BALTIMORE		1901	
MARRIAGE		DATE OF MARRIAGE	
MARRIED		1901	
EDUCATION		DATE OF EDUCATION	
HIGH SCHOOL		1901	
OCCUPATION		DATE OF OCCUPATION	
LABORER		1901	
RELIGION		DATE OF RELIGION	
CATHOLIC		1901	
MILITARY SERVICE		DATE OF MILITARY SERVICE	
NONE		1901	
PREVIOUS DEATH		DATE OF PREVIOUS DEATH	
NONE		1901	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH	
HEART DISEASE		1901	
MANNER OF DEATH		DATE OF MANNER OF DEATH	
NATURAL		1901	
PLACE OF DEATH		DATE OF PLACE OF DEATH	
BALTIMORE		1901	
DATE OF DEATH		1901	
TIME OF DEATH		1901	
SIGNATURE OF DECEASED		DATE OF SIGNATURE OF DECEASED	
JOHN JOHNSON		1901	
SIGNATURE OF WITNESS		DATE OF SIGNATURE OF WITNESS	
JOHN JOHNSON		1901	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE OF PHYSICIAN	
JOHN JOHNSON		1901	
SIGNATURE OF CLERK		DATE OF SIGNATURE OF CLERK	
JOHN JOHNSON		1901	

BUREAU V. S.

APR 24 1903

RECEIVED

4519

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE North Carolina b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carolina Beach 70 x-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Wilson Avenue	
3. NAME OF DECEASED (Type or print) First CLYDE Middle A. Last WOOTTON JR.		4. DATE OF DEATH Month April Day 3 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-12
9. AGE (In years lost birthday) yrs. 45		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Theatre	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clyde A. Wootton Sr.		14. MOTHER'S MAIDEN NAME Pearl Marie Wagner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 237-09-8776	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 587.0 Bronchopneumonia bilateral unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Chronic interstitial pancreatitis with atrophy DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			INTERVAL BETWEEN ONSET AND DEATH 4-5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 11, 19 50, to April 3, 19 58, and that death occurred at 9:20 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 4-4-58 ACTUAL SIGNATURE W. M. HARRIS M.D. PHYSICIAN'S NAME (Type) W. M. HARRIS Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/6/58	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY unknown	22d. LOCATION (City, town, or county) (State) Greensboro, North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Hayre de Grace, Md.		24a. REC'D BY REGISTRAR DATE APR 8 '58	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

APR 9 1959

RECEIVED